MARKET CONDUCT EXAMINATION REPORT
Dated October 15, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2010 THROUGH DECEMBER 31, 2010

GOLDEN RULE INSURANCE COMPANY
7440 Woodland Drive
Indianapolis, IN 46278

NAIC Company Code: 62286
NAIC Group Code: 707

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

GOLDEN RULE INSURANCE COMPANY
7440 Woodland Drive
Indianapolis, IN 46278

MARKET CONDUCT EXAMINATION REPORT
DATED OCTOBER 1, 2012

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Examination Performed by:

State Market Conduct Examiner

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Examiner-in-Charge

And

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COMPANY PROFILE

The following is taken directly from written documentation provided by Golden Rule Insurance Company and has not been independently verified by the Division of Insurance:

Golden Rule Insurance Company, ("Golden Rule") domiciled in the state of Indiana and a wholly owned subsidiary of Golden Rule Financial Corporation, is in the life and accident and health insurance business. The Company was incorporated on June 17, 1959 and commenced business on June 23, 1961. The Company has a certificate of authority from forty-nine (49) states and the District of Columbia, but currently does not actively offer products in all of them. It sells life, annuity, and accident and health policies through independent agents, sponsored marketing programs, internet, and direct selling with the vast majority of the Company's business being generated through a large network of independent agents. The Company's accident and health revenues are primarily derived from the sale of individual major medical policies.

Golden Rule began operations in Colorado on December 26, 1979. The Company is licensed to market health, life, and annuities in Colorado. In the health market, the Company offers hospitalization, long and short term medical, and health savings account (HSA) high deductible health plans to Colorado residents. Golden Rule Insurance Company is the business entity used. In accordance with the Articles of Incorporation, Golden Rule is managed by a board of directors. In 2003, Golden Rule became a UnitedHealthcare company, with UnitedHealth Group, Inc. being the ultimate parent company.

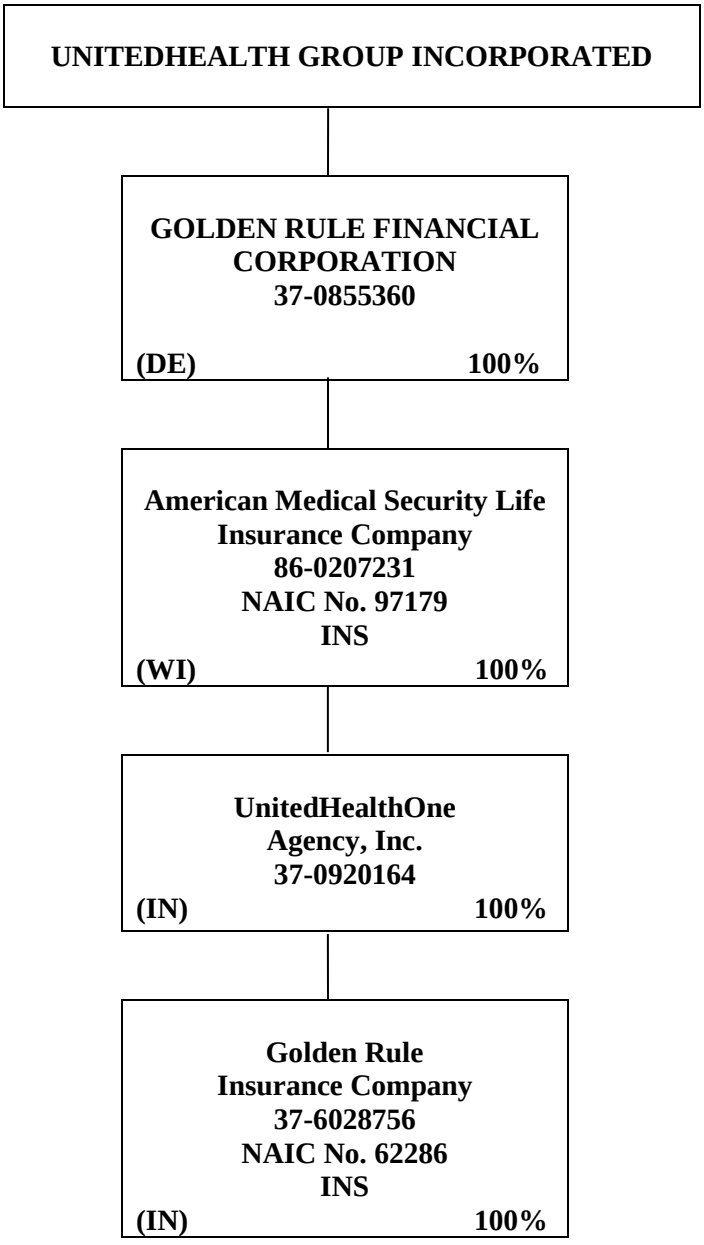
Golden Rule did not market group or association group health insurance plans in Colorado in 2010. It stopped marketing association group health insurance in Colorado on November 19, 2008 and started marketing true individual health insurance in Colorado on November 20, 2008. As some applications would already have been in process on November 19, 2008, Golden Rule continued to allow/accept group association health insurance until January 23, 2009. There was existing association group health insurance business still in effect in 2010.

Premium and Market Share as of December 31, 2010*:

Total Life, Accident and Health Written Premium ($1,000s)	$61,128
Market Share	1.49%

*As shown in the 2010 Edition of the Colorado Insurance Industry Statistical Report

Organizational Chart



PURPOSE AND SCOPE

A state market conduct examiner with the Colorado Division of Insurance ("Division"), who was assisted by independent contract examiners, reviewed certain business practices of Golden Rule Insurance Company ("Golden Rule" or "Company"). This market conduct examination ("MCE") was performed in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, and 10-1-205, C.R.S., as well as § 10-3-1106, C.R.S., which empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance. All work product developed in producing this report is the sole property of the Division.

The purpose of the examination was to determine Golden Rule's compliance with Colorado insurance laws related to large and small group and individual health insurance business in Colorado. Examination information contained in this report will serve only this purpose, except as otherwise provided by law pursuant to §§ 10-1-204 and 10-1-205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be a public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). They relied primarily on records and materials maintained and/or provided by the Company. This market conduct examination covered the period from January 1, 2010, through December 31, 2010.

The examination included review of the following:

Company Operations and Management
Producers
Contract Forms
New Business Applications and Renewals
Rating
Cancellations, Non-Renewals, Declinations and Rescissions
Claims Handling
Utilization Review

The examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared by the examiners identifying any concerns and/or discrepancies and provided to Golden Rule. The comment forms contained a section that permitted Golden Rule to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to accident and health insurance laws. Examination findings may result in administrative action by the Division. The examiners may not have discovered all unacceptable or non-complying practices of Golden Rule. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examiners reviewed all relevant statutes and regulations pertaining to health benefit plans.

Sampling Methodology

When sampling was necessary, the examiners reviewed files randomly selected from the larger population of files. Otherwise, the examiners reviewed the entire population of files. Per statute, the examiners used the most recent version (2011) of the NAIC Handbook ("Handbook") available at the commencement of the examination.

The samples taken and reviewed for this examination are discussed under each individual area of review outlined below.

Where the error rates of the samples indicated it would be appropriate to select an additional sample, but the examiners determined the initial results were conclusive, Golden Rule was afforded the opportunity to agree that the initial sample results were representative of the overall population or request that an additional sample be selected. In each such case, Golden Rule did not request that an additional sample be taken.

An error tolerance level of seven percent (7%) for claims and ten percent (10%) for other samples was established to determine reportable exceptions.

An error tolerance of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance was applied to identify possible system errors.

Prior Audits and Examinations

Golden Rule's most recent market conduct examination by the Division prior to this examination was completed in 2005 and covered an exam period of January 1, 2004 through December 31, 2004.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, administrative, underwriting and claims guidelines/procedures, and timely cooperation with the examination process.

Producers

The examiners reviewed the licensing status of the submitting producers for all individual business written and all policies declined during the period of the examination for compliance with the appropriate Colorado statutes and regulations.

Contract Forms

The examiners reviewed the following contract forms for compliance with Colorado insurance law:

Individual Health Policies:

Short Term Policy ES7	Form GRI-H-5.7-05
Signature HSA 100 EXL	Form MTI00001-05
HSA 100 EXH	Form MTI00001-05
HSA 100 EUH	Form GRI-N23M-05
HSA Saver EUG	Form GRI-N23S-05
Plan 100 EXI	Form MTI00001-05
Copay Saver EUE	Form GRI-N23S-05
Signature Select EXJ	Form MTI00001-05
Copay Select EUD	Form GRI-N23M-05
Saver 80 EUS	Form GRI-N23S-05
Saver 80 EXS	Form MTI00001-05
Signature Saver EXK	Form MTI00001-05
Copay Select EXD	Form MTI00001-05
Copay Saver EXE	Form MTI00001-05
Plan 80 EUI	Form GRI-N23M-05

Golden Rule's form numbers GRI-N23M-05 and GRI-N23S-05 reflect whether the coverages resemble a major medical coverage (GRI-N23M-05) or a hospital, surgical medical plan (GRI-N23S-05). Under each policy form number, the forms are built to allow multiple products to be offered with minimal changes to inside pages and most differences reflected on the variable Data Page.

Form number MTI00001-05 is the matrix form number for the policy face page for EX Plans which were built in a matrix format to allow flexibility of inside pages to construct the products to be made available.

Riders:

• Rider-Amendment to Policy	SA-S-9N
• Supplemental Accident Expense Benefits Rider	SA-S-640
• Basic Coverage Supplemental Accident Expense Benefits	SA-S-861-I
• Hospital Indemnity Rider	SA-S-1091-I
• Vision Benefit Rider	SA-S-1356R-05
• Copayment Amount Rider	SA-S-1418R
• Dental Insurance Rider	SA-S-1374-05
• Pregnancy Expense Benefits Rider	SA-S-1373-TI-05
• Term Life Insurance Rider	SA-S-1366
• Accidental Death Benefit Rider	SA-S-1367
• Patient Protection & Affordable Care Act Notice	SA-S-1504
• Patient Protection & Affordable Care Act Notice	39970-G PPACA NB

Applications:

Enrollment Form – American Community HSA GI	GRI-AP-123-05N2

Six (6) Individual Coverage Applications under the above name with the following "Used From" and "Used To" dates:

From 07/06/2010 to 08/15/2010

From 08/27/2010 to 09/23/2010
From 11/15/2010 to 12/31/2010
From 07/06/2010 to 08/15/2010
From 08/27/2010 to 09/02/2010
From 11/15/2010 to 12/31/1010

Application (Business Group of One) 37443-1009
Colorado Determination Of Self-Employed
From 09/24/2009 to 01/10/2011

STM-Short Term App and Rates 654D-G-1209
From 12/03/2009 to 02/04/2010

STM-Short Term App and Rates 654D-G-0210
From 02/04/2010 to 12/31/2010

Enrollment Form MAMSI GI Health Application 849D-G-0410
From 04/22/2010 to 06/25/2010

Enrollment Form MAMSI GI Health Application 849D-G-0610
From 06/25/2010 to 01/01/2011

Enrollment Form MAMSI GI Health Application 097E-G-1110
From 11/16/2010 to 12/31/2010

Enrollment Form-Nortel G Health Application 901D-G-0710
From 07/12/2010 to 09/15/2010

Application Platinum Health Application 836K-G-0310
From 03/25/2010 to 12/02/2010

Existing Customer Application-True Individual Health Application 825D-G-1009
From 11/09/2009 No "to" date provided

Enrollment Form PHS GI Health Application 029E-G-1010
From 11/16/2010 to 12/31/2010

Application Gen 23 Health Application 787D-G-1009
From 09/24/2009 to 03/25/2010

Application Gen 25 Health Application 834D-G-0310
From 03/25/2010 to 12/31/2010

Rates

The examiners reviewed the rates charged in the sample of individual new business files to verify compliance with the rate filings submitted to the Division as the rates being used during the examination period. The examiners also reviewed the Association Group rates for new business and renewal files.

New Business Applications and Renewals

For the period under examination, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- One hundred nine individual new business application files from a population of 10,339.

Golden Rule indicated in response to an inquiry from the examiners that it did not issue renewal business. Its business automatically renews as long as the insured continues to pay premiums. As a result there was no renewal process to review so no sample of renewal business was taken.

Cancellations, Non-Renewals, Declinations and Rescissions

For the period January 1, 2010 through December 31, 2010, samples of cancelled and declined files were selected using ACL ™ software and reviewed for compliance with statutory requirements and contractual obligations:

- One hundred eight individual cancellation files from a population of 5,659;
- One hundred seven individual declined files from a population of 2,763; and
- The entire population of seventeen (17) individual rescission files.

Claims

The following two (2) samples, selected using ACL ™ software were reviewed for overall claim handling and accuracy of processing:

- One hundred nine paid claims from a population of 149,952 claims received during the examination period; and
- One hundred nine denied claims from a population of 17,143 received during the examination period.

The following three (3) samples, selected using ACL ™ software, were reviewed to determine Golden Rule's compliance with Colorado's prompt payment of claims law:

- One hundred seven electronic claims from a population of 1,127 received during the examination period that were adjudicated in excess of thirty (30) calendar days;
- Seventy-six (76) non-electronic claims from a population of 189 claims received during the examination period that were adjudicated in excess of forty-five (45) calendar days; and
- One hundred four electronic and non-electronic claims from a population of 104 claims received during the examination period that were adjudicated in excess of ninety (90) calendar days.

Utilization Review

The examiners reviewed Golden Rule's utilization review (UR) management program including policies and procedures. For the period of January 1, 2010 through December 31, 2010, Golden Rule provided fifteen (15) files involving retrospective medical reviews. These files included the initial denial, any subsequent appeals and medical reviews. Golden Rule indicated these were the only instances of utilization review conducted during the period under examination. A review of the files produced the following numbers of first level, second level, and independent external reviews. The examiners reviewed all fifteen (15) files for compliance with statutory requirements:

- Eight (8) First Level Utilization Review Appeals;
- Five (5) Voluntary Second Level Utilization Review Appeals; and
- Two (2) Independent External Reviews.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of fifteen (15) findings in which Golden Rule was not in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: In the area of company operations and management, the examiners identified one (1) issue of concern in their review.

Issue A1: Certification and use of non-compliant forms.

Complaint Handling: In the area of complaint handling, no compliance issues were identified that met the reporting threshold to be included in this report.

Producers: In the area of producers, no compliance issues were identified that met the reporting threshold to be included in this report.

Contract Forms: In the area of contract forms, which included policies, applications and riders, the examiners identified twelve (12) issues of concern in their review.

Issue E1: Failure of the Company's forms, in some instances, to include coverage for services based on a licensed provider's status (e.g., an immediate family member). *(This was identified as a repeat of prior issue E3 in the 2004 examination report.)*

Issue E2: Failure of the Company's forms, in some instances, to include a complete description of the mandatory coverage for child health supervision services.

Issue E3: Failure of the Company's forms, in some instances, to include creditable coverage for certain conditions.

Issue E4: Failure of the Company's forms, in some instances, to reflect the correct upper age limit for treatment of congenital defects and birth abnormalities.

Issue E5: Removed from report.

Issue E6: Failure of the Company's forms, in some instances, to reflect mammography and prostate cancer screening that is exempt from deductibles if provided by a non-participating provider.

Issue E7: Failure to include the required definition of a "significant break in coverage" on its Certificate of Creditable Coverage form.

Issue E8: Failure of the Company's forms, in some instances, to reflect correct information in a cooperation provision concerning denial of claims.

Issue E9: Failure of the Company's forms, in some instances, to allow prescription drug benefits or diagnosis or treatment benefits due to a covered person's addiction to or dependency on tobacco.

Issue E10: Failure, in some instances, to reflect correct information with regard to measuring the number of days versus full months to be allowed for creditable coverage.

Issue E11: Failure, in some instances, to reflect the correct method of calculating interest on death benefits in an Accidental Death Insurance Rider.

Issue E12: Removed from report.

Rating: In the area of rating, no compliance issues were identified that met the reporting threshold to be included in this report.

New Business Applications: In the area of new business applications, no compliance issues were identified that met the reporting threshold to be included in this report.

Cancellations, Declinations and Rescissions: In the area of cancellations, declinations and rescissions, no compliance issues were identified that met the threshold to be included in this report.

Claims Handling: In the area of claims handling, the examiners identified two (2) issues of concern in their review.

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to correctly calculate the amounts of late payment interest and penalties due.

Utilization Review: In the area of utilization review, the examiners identified two (2) issues of concern in their review.

Issue K1: Failure, in some instances, to have initial denial of benefit letters or first level review adverse determinations signed by a licensed physician.

Issue K2: Failure, in some instances, to include all required information in the written notification of adverse decisions for first level reviews.

GOLDEN RULE INSURANCE COMPANY

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Certification and use of non-compliant forms.

Section 10-3-1104, C.R.S., Unfair methods of competition - unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

Section 10-16-107.2, C.R.S., Filing of health policies - rules, states in part:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. *Such listing* shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and *shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law*. The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. Golden Rule was not in compliance with Colorado insurance law in that not all forms that were certified and used by Golden Rule in 2010 were in compliance with statutory requirements as evidenced by Issues #E1 through #E4 and #E6 through #E11.

Recommendation No 1:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-3-1104, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that all forms issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company.

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to include coverage for services based on a licensed provider's status (e.g., an immediate family member). (*This was identified as a repeat of prior issue E3 in the 2004 examination report.*)

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (7) Reimbursement of providers.
>
> (a) Sickness and accident insurance.
>
> (I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or* plan *shall not be denied when such service is rendered by a person so licensed. . . .* [Emphasis added.]

Golden Rule was not in compliance with Colorado insurance law in that, in some instances, its forms excluded benefits for services performed by a provider who was a member of the insured person's immediate family.

A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., an immediate family member).

The forms listed below contain the following non-compliant language:

> GENERAL EXCLUSIONS AND LIMITATIONS
>
> . . . No benefits will be paid for any services performed by a member of a covered person's immediate family.

Form Name	Form Number	Date of Filing
Copay Select EXD	MTI00001-05	10/06/09
Copay Select EUD	GRI-N23M-05	06/11/08
Short Term ES7	GRI-H-5.7-05	05/18/06
HSA 100 EUH	GRI-N23M-05	06/11/08
Plan 80 EUI	GRI-N23M-05	06/11/08
Saver 80 EXS	MTI00001-05	10/06/09
Saver 80 EUS	GRI-N23S-05	06/11/08
Copay Saver EXE	MTI00001-05	10/06/09
Signature Saver EXK	MTI00001-05	10/06/09

Signature Select EXJ	MTI00001-05	10/06/09
HSA 100 EXH	MTI00001-05	10/06/09
Plan 100 EXI	MTI00001-05	10/06/09
HSA Saver EUG	GRI-N23S-05	06/11/08
Signature HSA 100 EXL	MTI00001-05	10/06/09
Copay Saver EUE	GRI-N23S-05	06/11/08

Recommendation No. 2:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised its forms and implemented procedures to provide reimbursement for covered services performed by a licensed provider if the provider normally charges for the services regardless of the provider's status as a member of the insured's immediate family as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

In the market conduct examination for the period of January 1, 2004 through December 31, 2004, Golden Rule was cited for failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member. The violation resulted in Recommendation #3 of Final Agency Order O-06-055 that indicated the Company should revise all applicable forms to reflect that benefits may not be denied based solely on a provider's status, such as a family member, to ensure compliance with Colorado insurance law. Having been previously ordered to revise its forms in this manner, the Company knew or should have reasonably known that its continued use of such forms during the current examination period constituted a repeat violation of § 10-16-104, C.R.S., providing grounds for an increased penalty pursuant to § 10-1-205(3)(d), C.R.S.

Issue E2: Failure of the Company's forms, in some instances, to include a complete description of the mandatory coverage for child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105(7.2), to dependent children up to age thirteen. . . .

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services.

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS
FOR THE STATE OF COLORADO
Colorado Division of Insurance
January 1, 2010

Attachment 1

COVERED PREVENTIVE SERVICES	
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.

Golden Rule was not in compliance with Colorado insurance law in that the coverage provided by the policies identified below did not provide for the required "newborn home visit" coverage during the first week of life if the newborn was released from a hospital less than forty-eight (48) hours after delivery.

Form Name	Form Number	Date of Filing
Copay Select EXD	MTI00001-05	10/06/09
Copay Select EUD	GRI-N23M-05	06/11/08
Short Term ES7	GRI-H-5.7-05	05/18/06
HSA 100 EUH	GRI-N23M-05	06/11/08
Plan 80 EUI	GRI-N23M-05	06/11/08

Saver 80 EXS	MTI00001-05	10/06/09
Saver 80 EUS	GRI-N23S-05	06/11/08
Copay Saver EXE	MTI00001-05	10/06/09
Signature Saver EXK	MTI00001-05	10/06/09
Signature Select EXJ	MTI00001-05	10/06/09
HSA 100 EXH	MTI00001-05	10/06/09
Plan 100 EXI	MTI00001-05	10/06/09
HSA Saver EUG	GRI-N23S-05	06/11/08
Signature HSA 100 EXL	MTI00001-05	10/06/09
Copay Saver EUE	GRI-N23S-05	06/11/08

Recommendation No. 3:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, Golden Rule may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the benefits to be provided for preventive child health supervision services as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E3: Failure of the Company's forms, in some instances, to include creditable coverage for certain conditions.

Section 10-16-102, C.R.S., Definitions, states in part:

. . .

(13.7) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare, medicaid, or the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.;

(b) An employee welfare benefit plan or group health insurance or health benefit plan;

(c) An individual health benefit plan;

(d) A state health benefits risk pool (including but not limited to CoverColorado); or

(e) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act" (22 U.S.C. Sec. 2504 (e)).

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

. . .

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. …

Golden Rule was not in compliance with Colorado insurance law in that in the following contracts, coverage was excluded for the first six (6) months for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs unless provided on an emergency basis. Excluding coverage for certain conditions during the first six (6) months of a policy has the ability, and suggests the intent, to avoid giving credit for previous creditable coverage towards pre-existing condition exclusions.

The Company's forms stated the following:

GENERAL EXCLUSIONS/LIMITATIONS

Expenses incurred by a *covered person* for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs will not be covered during the *covered person's* first six months of coverage under this *policy*. This exclusion will not apply if the treatment is provided on an *emergency basis*.

After the six-month period, the condition will be subject to all the terms of this *policy*, just like any other condition.

Form Name	Form Number	Date of Filing
Copay Select EXD	MTI00001-05	10/06/09
Copay Select EUD	GRI-N23M-05	06/11/08
HSA 100 EUH	GRI-N23M-05	06/11/08
Plan 80 EUI	GRI-N23M-05	06/11/08
Saver 80 EXS	MTI00001-05	10/06/09
Saver 80 EUS	GRI-N23S-05	06/11/08
Copay Saver EXE	MTI00001-05	10/06/09
Signature Saver EXK	MTI00001-05	10/06/09
Signature Select EXJ	MTI00001-05	10/06/09
HSA 100 EXH	MTI00001-05	10/06/09
Plan 100 EXI	MTI00001-05	10/06/09
HSA Saver EUG	GRI-N23S-05	06/11/08
Signature HSA 100 EXL	MTI00001-05	10/06/09
Copay Saver EUE	GRI-N23S-05	06/11/08

Recommendation No. 4:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S. In the event the Company is unable to provide such documentation, Golden Rule may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the possibility of creditable coverage reducing or eliminating the time period applicable for coverage to be available for any preexisting conditions as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E4: Failure of the Company's forms, in some instances, to reflect the correct upper age limit for treatment of congenital defects and birth abnormalities.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.7) Therapies for congenital defects and birth abnormalities.

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday *to the child's sixth birthday.* [Emphasis added.]

Golden Rule was not in compliance with Colorado insurance law in that the individual coverage policy "Short Term ES7" provided coverage for treatment of congenital defects and birth abnormalities only up to five years of age instead of through five years of age.

Page 13, Section 7 of the policy reflects:

MAJOR MEDICAL BENEFITS

. . .

(X) For congenital defects and birth abnormalities for children up to five years of age. . . .

Form Name	Form Number	Date of Filing
Short Term ES7	GRI-H-5.7-05	05/18/06

Recommendation No. 5:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct upper age limit for therapies to be provided for congenital defects and birth abnormalities as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E5: Removed from report.

Issue E6: Failure of the Company's forms, in some instances, to reflect mammography and prostate cancer screening that is exempt from deductibles if provided by a non-participating provider.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (10) Prostate cancer screening.
>
> (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article *shall not be subject to policy deductibles*.
>
> . . .
>
> (18) Preventive health care services.
>
> . . .
>
> (a)(III) *Coverage shall not be subject to policy deductibles* or coinsurance. Copayments may apply as required by the policy, contract, or other health care coverage.
>
> . . .
>
> (b)(III)(A) Breast cancer screening with mammography. [Emphases added.]

Golden Rule was not in compliance with Colorado insurance law in that the "Patient Protection and Affordable Care Act Notice" and the "Patient Protection and Affordable Care Act Rider" in use by the Company to provide Colorado specific benefits failed to comply in the following ways:

- They reflected that preventive health services are exempt from any deductible amounts under the policy only when the services are provided by a preferred provider or network provider. The preventive health services for prostate cancer screening and mammography breast cancer screening are not to have a deductible applied whether services are provided by a participating provider or a non-participating provider.

Page 1 of the "Patient Protection and Affordable Care Act Notice" reflected:

. . .

L. Charges incurred for the following preventive health services that are appropriate for the covered person will be covered in accordance with the following recommendations and guidelines in effect as of March 23, 2010:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Page 2 of the "Patient Protection and Affordable Care Act Notice" reflected:

Benefits for the preventive health services listed under L above are exempt from any waiting period, deductible, coinsurance and copayment *when the services are provided by a preferred provider or network provider* (whichever is defined in your policy/certificate). [Emphasis added.]

Page 1 of the "Patient Protection and Affordable Care Act Rider" reflected:

. . .

L. *Covered expenses* under the policy are amended to the extent necessary to include the charges incurred by *a covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines in effect as of March 23, 2010:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Page 2 of the "Patient Protection and Affordable Care Act Rider" reflected:

Benefits for the preventive health services listed under paragraph L above are exempt from any *deductible amounts*/stated deductibles, coinsurance provisions and *copayment amounts* under the *policy* when the services are provided by a *preferred provider* or *network provider* (whichever is defined in your *policy*).

Form Name	Form Number	Date of Filing
Patient Protection & Affordable Care Act Notice	39970-G PPACA NB	09/23/10
Patient Protection & Affordable Care Act Rider	SA-S-1504	08/05/10

Recommendation No. 6:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect that the preventive health services of mammograms and prostate cancer screenings, are exempt from a deductible whether the services are provided by a network provider or a non-network provider as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E7: Failure to include the required definition of a "significant break in coverage" on its Certificate of Creditable Coverage form.

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

. . .

B. Colorado law concerning creditable coverage.

. . .

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added.]

Golden Rule was not in compliance with Colorado insurance law in that the Certificate of Creditable Coverage form in use by the Company during the examination period failed to define a significant break in coverage.

Form Name	Form Number
Certificate of Creditable Coverage	17100 PLT550-1

Recommendation No. 7:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-18. In the event Golden Rule is unable to provide such documentation, the Company may include, with it submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written documentation to the Division that it has revised its Certificate of Creditable Coverage to include the definition of a "significant break in coverage" that is in compliance with Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E8: Failure of the Company's forms, in some instances, to reflect correct information in a cooperation provision concerning denial of claims.

Section 10-3-1104, C.R.S., Unfair methods of competition - unfair or deceptive acts or practices, states in part:

> . . .
>
> (1)(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> . . .
>
> (III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or
>
> (IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or
>
> (V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; or
>
> . . .
>
> (XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> . . .
>
> (4)(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

The policies identified below were not in compliance with Colorado insurance law in that they reflected a statement in a claims "Cooperation Provision" that is not allowed under Colorado insurance law and

which represented an unfair claim settlement practice. Colorado insurance law does not allow for the denial of claims for all persons covered under a policy if there is failure of one covered person to provide the additional information needed to process their particular claim. Each claim must be treated individually and paid, settled or denied according to the requirements of Colorado insurance law.

Page 29 of the "Copay Saver EUE", "Copay Select EUD", "HSA 100 EUH", "HSA Saver EUG", "Saver 80 EUS" policies;
Pages 29-30 of the "Plan 80 EUI" policy;
Page 40 of the "Saver 80 EXS", "Signature Saver EXK", and "Copay Saver EXE" policies;
Page 41 of the "HSA 100 EXH", "Signature Select EXJ", and "Signature HSA 100 EXL" policies; and
Page 42 of the "Copay Select EXD" and "Plan 100 EXI" policies reflect:

> Section 13 CLAIMS
>
> COOPERATION PROVISION:
>
> . . .
>
> "In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*."

Form Name	Form Number	Date of Filing
Copay Select EUD	GRI-N23M-05	06/11/08
Saver 80 EUS	GRI-N23S-05	06/11/08
Saver 80 EXS	MTI00001-05	10/06/09
Signature Saver EXK	MTI00001-05	10/06/09
HSA 100 EUH	GRI-N23M-05	06/11/08
Plan 80 EUI	GRI-N23M-05	06/11/08
Copay Saver EXE	MTI00001-05	10/06/09
Copay Select EXD	MTI00001-05	10/06/09
Signature Select EXJ	MTI00001-05	10/06/09
HSA 100 EXH	MTI00001-05	10/06/09
Plan 100 EXI	MTI00001-05	10/06/09
HSA Saver EUG	GRI-N23S-05	06/11/08
Signature HSA 100 EXL	MTI00001-05	10/06/09
Copay Saver EUE	GRI-N23S-05	06/11/08

Recommendation No. 8:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104 and 10-16-106.5, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to remove the part of the

claims "Cooperation Provision" that is not in compliance with Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

In addition, the Company shall conduct a self-audit of all medical claims received January 1, 2009, through October 21, 2011, to determine if any claims were improperly denied for lack of additional information. Golden Rule shall adjudicate each such claim, paying benefits due as well as any interest and penalty owed, to the appropriate individual and provide a report of the self-audit to the Division no later than ninety (90) days from the date this report is adopted.

Issue E9: Failure of the Company's forms, in some instances, to allow prescription drug benefits or diagnosis or treatment benefits due to a covered person's addiction to or dependency on tobacco.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(18) Preventive health care services.

(a)(I) Except as specified in subparagraph (II) of this paragraph (a), the following policies and contracts that are delivered, issued, renewed, or reinstated on or after January 1, 2010, shall provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18):

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to part 2 of this article;

(b) The coverage required by this subsection (18) shall include preventive health care services for the following, in accordance with the A or B recommendations of the task force for the particular preventive health care service:

. . .

(IX) Tobacco use screening of adults and tobacco cessation interventions by primary care providers.

Golden Rule's "Prescription Drug Expense Benefits Rider" was not in compliance with Colorado insurance law in that it incorrectly excluded prescription benefits due to a covered person's addiction to, or dependency on, tobacco. Colorado insurance law required that coverage be provided for prescription items related to cessation of tobacco use.

Page 2 of the Rider reflects:

EXCLUSIONS AND LIMITATONS:

No benefits will be paid under this rider for expenses:

. . .

G. Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

Additionally, Golden Rule's Short Term Policy ES7 was not in compliance with Colorado insurance law in that it incorrectly excluded benefits due to addiction to, or dependency on tobacco. Colorado insurance law requires that coverage be provided for tobacco use screening and cessation interventions.

Page 21 of the Policy reflects:

GENERAL EXCLUSIONS AND LIMITATIONS:

Covered expenses will not include, and no benefits will be paid for, any charges that are incurred:

(AB) For diagnosis or treatment of nicotine addiction.

Form Name	Form Number	Date of Filing
Outpatient Prescription Drug Expense Benefits Rider	SA-S-1347	06/11/08
Short Term Policy ES7	GRI-H-5.7-05	05/18/06

Recommendation No. 9:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to eliminate exclusions for prescription items related to tobacco cessation and for diagnosis or treatment of nicotine addiction in accordance with Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E10: Failure, in some instances, to reflect correct information with regard to measuring the number of days versus full months to be allowed for creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

. . .

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period *for the period of time an individual was previously covered by creditable coverage* if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule. [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

. . .

3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C. R. S.; 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). *These sections concern the method for counting creditable coverage*: . . . and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates. [Emphasis added.]

45 C.F.R., 146.113, Rules Relating to Creditable Coverage, states in part:

. . .

(b) Standard method

. . .

(2) Counting creditable coverage

(i) *Based on days*. For purposes of reducing the preexisting condition exclusion period that applies to an individual, *the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage.* Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage. [Emphases added.]

Golden Rule was not in compliance with Colorado insurance law in that the policies identified below had an incorrect provision for determining the amount of Creditable Coverage to be considered. A period of Creditable Coverage is to be measured in "days" not the number of "full months".

Page 25 of Policies "Saver 80 EUS", "HSA 100 EUH", "HSA Saver EUG" and "Copay Saver EUE";
Page 34 of Policies "Saver 80 EXS", "Signature Saver EXK", and "Copay Saver EXE";
Page 26 of Policies "Copay Select EUD" and "Plan 80 EUI";
Page 36 of Policies "Copay Select EXD" and "Plan 100 EXI"; and
Page 35 of Policies "Signature Select EXJ", "HSA 100 EXH" and "Signature HSA 100 EXL", reflect:

. . .

Section 10 **PREEXISTING CONDITIONS LIMITATION**

Waiver of Preexisting Condition Exclusion: If a *covered person* was insured under *creditable coverage* within the 90 days prior to his or her *effective date* of coverage under this *policy*, the *covered person* will be entitled to credit under the 12-month *preexisting conditions* exclusion for the number of full months he or she was continuously covered under the prior *creditable coverage*. [Emphases added.]

Form Name	Form Number	Date of Filing
Copay Select EUD	GRI-N23M-05	06/11/08
Saver 80 EUS	GRI-N23S-05	06/11/08
Saver 80 EXS	MTI00001-05	10/06/09
Signature Saver EXK	MTI00001-05	10/06/09
HSA 100 EUH	GRI-N23M-05	06/11/08
Plan 80 EUI	GRI-N23M-05	06/11/08
Copay Saver EXE	MTI00001-05	10/06/09
Copay Select EXD	MTI00001-05	10/06/09
Signature Select EXJ	MTI00001-05	10/06/09
HSA 100 EXH	MTI00001-05	10/06/09
Plan 100 EXI	MTI00001-05	10/06/09
HSA Saver EUG	GRI-N23S-05	06/11/08
Signature HSA 100 EXL	MTI00001-05	10/06/09
Copay Saver EUE	GRI-N23S-05	06/11/08

Recommendation No. 10:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event Golden Rule is unable to provide documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised all applicable forms to reflect that credit will be given under the 12 month preexisting conditions exclusion for the number of days, not full months, an insured was continuously covered under the prior creditable coverage as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and the proposed date the revised forms will be put in use.

Issue E11: Failure, in some instances, to reflect the correct method of calculating interest on death benefits in an Accidental Death Insurance Rider.

Section 10-7-112, C.R.S., Interest payable on benefits or proceeds, states in part:

> (1) Notwithstanding any other provision of law, each insurer admitted to transact the business of life insurance in this state shall pay interest on the death benefits using an *interest rate that is not less than the rate of interest for proceeds left on deposit with the insurer and subject to withdrawal on demand for the period beginning at the date of death through thirty days following the date of receipt by the insurer of a complete request for payout including due proof of death. From that date until the date of settlement of the clam, the annual rate of interest shall be two percentage points above the federal discount rate, which rate shall be the rate of interest a commercial bank pays to the federal reserve bank of Kansas City using a government bond* or other eligible paper as security and shall be rounded to the nearest full percent. . . .
>
> . . .
>
> (4) For the purposes of this section, the term *"life insurance" shall include*:
>
> . . .
>
> (e) *Life insurance benefits payable under accident only type policies*; [Emphases added.]

Golden Rule was not in compliance with Colorado insurance law in that their method of calculating interest on death benefits as expressed in the Company's Accidental Death Insurance Rider was incorrect in the following ways:

- Interest is to be calculated from the period beginning at the date of death through thirty (30) days following the date of receipt by the insurer of a complete request for payout which includes due proof of death. After that, the interest rate shall be two (2) percentage points above the federal reserve rate based on the Kansas City federal reserve bank. The Rider only reflected that if proceeds are not paid within thirty (30) days after receipt of due proof of death interest is to be paid on the proceeds.

- The interest rate is not to be less than the rate of interest for proceeds left on deposit with the insurer and subject to withdrawal on demand for the period beginning at the date of death through thirty (30) days following the date of receipt of a complete request for payout. The Rider reflects that interest will be paid at the rate of 3% a year; however, the Company has indicated that the interest rate for proceeds left on deposit was 4% during 2010.

Page 2 of the Accidental Death Insurance Rider reflected:

> If *proceeds* are not paid within 30 days after *we* received *due proof of death we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date we receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

Form Name	Form Number	Date of Filing
Accidental Death Insurance Rider	SA-S-1367	06/11/08

Recommendation No. 11:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-7-112, C.R.S. In the event Golden Rule is unable provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable forms to reflect the correct method of calculating interest on death benefits as required by Colorado insurance law. Within these sixty (60) days, Golden Rule shall also provide the Division with specimen copies of all forms that had previously contained the non-compliant language and provide the proposed date the revised forms will be put in use.

Issue E12: Removed from report.

CLAIMS HANDLING

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states, in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents*. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. [Emphasis added.]

. . .

(4)(a) Clean claims shall be paid, denied, or settled within *thirty calendar days after receipt* by the carrier if submitted electronically and within *forty-five calendar days after receipt* by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Golden Rule was not in compliance with Colorado insurance law in that it failed to pay, deny or settle 64 claims from a total population of 104 claims adjudicated more than ninety (90) days after receipt within the required ninety (90) calendar days. There was no indication in the claim records that any of the cited claims involved fraud. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

CLAIMS EXCEEDING 90 DAYS TO PAY, DENY OR SETTLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
104*	104	64	61%

*(0.06% of all claims received)

Recommendation No. 12:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has reviewed its claims processing quality controls to ensure that all claims are adjudicated within the required time periods as required by Colorado insurance law.

Issue J2: Failure, in some instances, to correctly calculate the amounts of late payment interest and penalties due.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> . . .
>
> (4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> . . .
>
> (5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, *shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim,* accruing from the date payment was due pursuant to subsection (4) of this section.
>
> (b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim *shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim.* Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

Golden Rule's claims processing system automatically calculates interest for claims processed within ninety (90) days of receipt of the claim, regardless if they were entered by the Data Capture Vendor or not. The "Data Capture Vendor" is Golden Rule's vendor, not a clearinghouse for the providers. However, adjustor intervention is required to appropriately apply the interest and late payment penalty when the processing of the claim exceeds ninety (90) days.

The Data Capture Vendor converts claims submitted via paper into electronic data elements for the system. No claim processing responsibility is conducted by the Data Capture Vendor, including but not limited to, interest and penalty calculations.

Claims that were entered into the system via the Data Capture Vendor appear to the system to be electronic claims and therefore, the stricter time frame is applied when the interest is calculated by the system. This results in a higher interest amount being paid than what is owed. However, if the adjustor is manually calculating the interest and/or penalty that are due, the adjustor is supposed to treat the claim entered by the Data Capture Vendor as a paper submission, not electronic.

In numerous instances penalty amounts for late payment of claims were overpaid. The Company indicated the cause of this to be as follows:

> When a claim exceeded ninety (90) days, it required adjustor intervention and the adjustor received a warning message when appropriate. As the claim was being processed, the system automatically added 10%. If the adjustor intervened and added an additional 20%, without considering the 10% that was added by the system, the result would be a 30% penalty being paid.

The Company indicated that a system change is planned to address this issue to reduce the need for adjustor intervention.

There were also instances of underpayment of late payment interest/penalties. The Company issued payment for any underpayments revealed by this examination of claims (with the exception of one (1) file due to the minimal amount of $0.02) and provided documentation in the form of copies of the explanation of benefits forms to the examiners. The Company indicated it would not be requesting return of any overpayments revealed by this examination of claims.

Golden Rule was not in compliance with Colorado insurance law in that it failed, in some instances, to pay the correct amount of interest and penalty on claims paid in excess of ninety (90) days.

ALL CLAIMS OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Total Error Rate
104*	104	46	44%

(*0.06% of all claims)

Recommendation No. 13:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all late payment interest and penalties that are due are properly calculated as required by Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to have initial denial of benefit letters or first level review adverse determinations signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

> (1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.
>
> . . .
>
> (4) All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient *shall be signed by a licensed physician familiar with standards of care in Colorado*. . . . [Emphasis added.]

Golden Rule was not in compliance with Colorado insurance law in that in all fifteen (15) instances where a benefit was denied retrospectively, the Company's letters of denial for reimbursement of medical treatment as not medically necessary, appropriate, effective, or efficient were not signed by a licensed physician. The letters were sent out over the typed signature of a "Case Management Analyst" and the letters referenced enclosure of the doctor's opinion. In some instances, the doctor's opinion did not include a doctor's name or signature and in others, the doctor's opinion reflected only the typed name of Golden Rule's Medical Director who is a physician.

Denial Letters Failing to Identify or Contain the Signature of a Licensed Physician

Population	Number of Exceptions	Total Error Rate
15	15	100%

Recommendation No. 14:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-113, C.R.S. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has instituted corrective procedures to ensure that all written denials of benefits on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient are signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law.

Issue K2: Failure, in some instances, to include all required information in the written notification of adverse decisions for first level reviews.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

. . .

Section 10. First Level Review

. . .

I. The decision issued pursuant to Subsection G. shall set forth in a manner calculated to be understood by the covered person:

1. *The name,* title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers".); [Emphasis added.]

2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;

J. A first level review decision involving an adverse determination issued pursuant to Subsection G. shall include, in addition to the requirements of Subsection I.:

. . .

2. *A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection F.2., to the covered person's benefit request*;

. . .

6. A description of the process to obtain a voluntary second level review, including:

a. *The written procedures governing the voluntary second level review, including any required time frames for the review;*

b. *The right of the covered person to:*

(i) *Request the opportunity to appear in person before a health care professional . . .*

(ii) *Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;*

(iii) *Present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;*

(a) *A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) days prior to the date of the review meeting.*

(b) *Any new material developed after the five-day deadline shall be provided to the carrier when practicable;*

(iv) *Present the covered person's case to the reviewer or review panel;*

(v) *If applicable, ask questions of the reviewer or review panel; and*

(vi) *Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;*

c. *A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.*

d. *A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.* [Emphases added.]

Golden Rule was not in compliance with Colorado insurance law in that its adverse decision notifications for first level reviews did not reflect the required notification information as follows:

- One (1) adverse decision notification did not include the name of the physician evaluating the appeal.

- The only information concerning further appeals in one adverse decision notification letter was: "If you do not agree with this determination, you may request an appeal in writing. You may include any other information that you want us to consider. We will review it and notify you of our findings."

First Level Appeal Adverse Determination Notifications

Population	Sample	Number of Exceptions	Total Error Rate
8	8	2	25%

Recommendation No. 15:

Golden Rule shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event Golden Rule is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Golden Rule shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that notifications of adverse decisions for first-level utilization reviews include all information required by Colorado insurance law.

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Examination Report Submission

State Market Conduct Examiner

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC

And

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Submit this report on this 15th day of October 2012 to:

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